Supreme Judicial Court

FOR THE COMMONWEALTH OF MASSACHUSETTS

NO. SJC-11178

RICHARD MEDINA,
PLAINTIFF-APPELLANT,

v.

FRANCINE PILLEMER AND FRED H. HOCHBERG, M.D. ET AL.,
DEFENDANTS-APPELLEES.

ON DIRECT APPELLATE REVIEW FROM JUDGMENTS AND RULINGS OF
THE SUPERIOR COURT DEPARTMENT OF THE TRIAL COURT

BRIEF OF AMICUS CURIAE
MASSACHUSETTS DEFENSE LAWYERS ASSOCIATION

By the Attorney for the
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STATEMENT OF THE INTEREST OF THE AMICUS CURIAE

The Massachusetts Defense Lawyers Association ("MassDLA"), amicus curiae, is a voluntary, non-profit, state-wide professional association of trial lawyers who defend corporations, individuals and insurance companies in civil lawsuits. Members of the MassDLA work to promote the administration of justice, legal education, and professional standards and to promote collegiality and civility among all members of the bar. As an association of civil defense lawyers, the MassDLA has a direct interest in the issues of public importance that affect MDLA members and their clients. Those interests could be affected by the issue before the Court in this appeal, including the scope of the duty of care owed by healthcare providers to third-parties. As part of fulfilling its purpose, the MassDLA has filed amicus briefs in the appellate courts of the Commonwealth before, including on a case involving a similar issue. See, Leavitt v. Brockton Hospital, 454 Mass. 37 (2009). The MassDLA offers its experience and perspective to the Court as amicus curiae to assist in its resolution of the matter now before it.

ISSUE PRESENTED

Whether a physician owed a duty of care to a pedestrian struck by his patient, based on that physician's alleged duty to warn his patient of the risks of driving posed by his underlying health condition?

STATEMENT OF THE CASE

The MDLA adopts by reference the Statement of the Case contained in the Brief of the Defendant-Appellee, Fred H. Hochberg, M.D. at pp. 2-9.

SUMMARY OF THE ARGUMENT

The plaintiff is asking this Court to find that a duty existed between a medical provider and a pedestrian based on that physician's duty toward the patient that struck him while having a seizure. The plaintiff bases this duty on his contention that the defendant physician, Dr. Hochberg, failed to advise his patient, with a prior history of seizure due to a brain tumor, not to drive and that Dr. Hochberg affirmatively indicated to his patient that he could drive. Plaintiff argues that this duty is based in common negligence and upon the theory that physician-patient relationship constitutes a "special relationship."

This Court has previously rejected both arguments in the landmark cases of Coombes v. Florio, 450 Mass. 182 (2007) (infra at Sec. I. B.), Leavitt v. Brockton Hospital, 454 Mass. 37 (2009) (infra at Sec. III. B.).

First, the duty raised by the plaintiff goes well beyond the bounds of the narrow holding allowing physician third party liability for failure to warn about the effects of prescription medications as set out in the Coombes decision. (See pp. 13-15). While the Justices in that case disagreed about several aspects of this holding, there was uniform agreement that physician liability should not be extended to third parties where it would threaten clinical decision making or the autonomy of the physician relationship. Also, the plurality opinion in Coombes focused on the duty to warn of the risks posed by prescription medications, not the underlying patient condition which is central here. Sound public policy weighs against any further extension of the Coombes duty to warn. (See pp. 15-20).

Second, Plaintiff contends the formation of the duty under Coombes necessarily extends to all who could be foreseeably put at risk. The Court should not find a duty here as it is beyond the bounds of

foreseeability where the physician did not provide care which created a special risk for driving. (See pp. 20-26). It was instead, the patient's own dormant disease without any preceding symptoms to forecast the seizure, which created this risk. It is not, therefore, foreseeable that any persons on a public roadway or sidewalk, including plaintiff would be placed at risk by allowing an essentially asymptomatic patient to drive.

Finally, the Court in accord with its legal precedent in both Coombes and Leavitt, rejected plaintiff's contention that the physician-patient relationship is a special relationship given the lack of control a physician has over his patient. (See pp. 26-36).

ARGUMENT

I. THE COURT SHOULD NOT EXTEND THE DUTY OF CARE A PHYSICIAN OWES TO A PATIENT TO THE DRIVING PUBLIC, WELL BEYOND THE NARROW CONFINES OF THE COOMBES DECISION

A. Duty of Care

Plaintiff is asking the Court to find a duty of care existed between a pedestrian and the physician of a patient who struck the plaintiff while having a seizure on the roadway. The physician only directly

owes the duty to his patient, thus plaintiff asks the Court to extend this duty of care to a third-party outsider to that protected relationship. Whether under the principles of general negligence (infra at Sec. I. B.) or the doctrine of "special relationships" (infra at Section III), plaintiff's arguments have previously been raised and rejected by this Court as a matter of law, most notably in Coombes v. Florio, 450 Mass. 182 (infra at Sec. I. B.), Leavitt v. Brockton Hospital, 454 Mass. 37 (2009) (infra at Sec. III. B.).

To prevail on a negligence claim, a plaintiff must prove that the defendant owed the plaintiff a duty of reasonable care, that the defendant breached this duty, that damage resulted, and that there was a causal relation between the breach of the duty and the damage. Jupin v. Kask, 447 Mass. 141, 146 (2006). The existence of a legally recognized duty of care is a question of law for the court to decide, Leavitt, 454 Mass. 37; Wallace v. Wilson, 411 Mass. 8, 12 (1991); Peters v. Haymarket Leasing, Inc., 64 Mass.App.Ct. 767, 775 (2005), and the appropriate subject of a motion for summary judgment pursuant to Rule 56 of the Massachusetts Rules of Civil Procedure. Cassesso v. Commissioner of Correction, 390 Mass. 419, 422 (1983).

See Remy v. MacDonald, 440 Mass. 675, 677 (2004) ("if not such duty exists, a claim for negligence cannot be brought").

The court determines whether a duty exists by referring to "existing social values and customs, as well as to appropriate social policy." Davis v. Westwood Group, 420 Mass. 739, 743 (1995).

> The concept of "duty" is not sacrosanct in itself, but is only an expression of the sum total of considerations of policy which lead the law to say that the plaintiff is entitled to protection. . . No better general statement can be made than that the courts will find a duty where, in general, reasonable persons would recognize it and agree that it exists.

Luoni v. Berube, 431 Mass. 729, 735 (2000), quoting W.L. PROSSER & W.P. KEETON, TORTS § 53, at 358-59 ed. 1984); see also Cremins v. Clancy, 415 Mass. 289, 292 (1993). As a general principle of law, every person has a duty to exercise reasonable care to avoid harming others. Jupin v. Kask, 447 Mass. 141, 147 (2006). A duty of care is imposed when the risk of harm is recognizable or foreseeable to the actor. Id. Otherwise stated, "to the extent a legal standard does exist for determining the existence of a tort duty . . ., it is a test of the reasonable foreseeability of the harm." Id. at 148 (internal quotation and citation omitted).

Prior to this Court's decision in Coombes v. Florio, 450 Mass. 182, 190 (2007), it had generally been recognized in the Commonwealth that in a medical malpractice context a physician's duty of care extended only to those with whom the physician had a physician-patient relationship. St. Germain v. Pfeifer, 418 Mass. 511, 520 (1994); see RESTATEMENT (THIRD) OF TORTS § 41 cmt. h (Proposed Final Draft No. 1 (2008)) ("Unlike most duties, the physician's duty to the patient is explicitly relational: Physicians owe a duty of care to *patients.")* (emphasis in original). The existence of a physician-patient relationship, therefore, is generally an element of a medical-malpractice case. Kapp v. Ballantine, 380 Mass. 186-93 (1980); Santos v. Kim, 429 Mass. 130, 134-35 (1999).

B. This Court's Decision in Coombes v. Florio

In Coombes v. Florio, this Court carved out a narrow exception to the general rule that a physician does not owe a duty to prevent harm to a nonpatient. The Court in Coombes held that a physician owes a duty of care to third-party nonpatients who are foreseeably put at risk by the physician's failure to warn a patient about the effects of prescription medications.

Id. Importantly, while liability to a nonpatient third-party was found based on a physician's duty to warn a patient about the effects of his prescribing, it did not extend to the physician's "very decision of what medication to prescribe or what treatment to pursue." Id. at 191-92. Although the Court's holding in Coombes established "for the first time in this Commonwealth a physician's duty to prevent harm to nonpatients," it was expressly limited to the physician's duty to warn. Id. at 201 (Marshall, CJ., dissenting).

The plaintiff in Coombes was the mother and administratrix of a ten-year old boy, who was killed when he was struck by a car driven by a patient of the defendant, Dr. Robert Florio. Id. at 183-86. The plaintiff alleged that the physician had prescribed the patient medications that caused drowsiness, dizziness, lightheadedness, fainting, altered consciousness, and sedation; that he had failed to warn the patient of these side effects; and that this failure was a proximate cause of the accident. The doctor last saw the patient two and a half months before the accident. Id. The trial court granted summary judgment for Dr. Florio on the ground that a physician owes no duty of care to anyone other than his patient. This Court, in

an especially divided decision, reversed the grant of summary judgment for Dr. Florio.

Justice Ireland wrote the opinion for the majority, which was joined by Justices Spina and Cowin. Justice Greaney agreed with the decision to reverse the grant of summary judgment for the physician, but disagreed with the broad scope of the duty established by the majority. Chief Justice Marshall and Justice Cordy authored dissenting opinions expressing their view that a physician owes no duty to a nonpatient arising from the treatment of a patient. Id. at 202, 206-07.

Justice Greaney believed that a physician's duty should extend to a nonpatient foreseeably harmed by a physician's failure to warn a patient about the risks of operating a motor vehicle while under the influence of a prescription medication. Id. at 196 (Greaney, J., concurring in part and dissenting in part).

Despite the disagreement about several aspects of the opinion, all of the Justices in Coombes shared a concern that imposing on a physician a duty to nonpatient litigants presents the danger of impinging on the autonomy of the physician-patient relationship. This concern was voiced perhaps most strongly by

Justice Cordy, who, in criticizing the new duty created by the majority, wrote "It would alter a physician's affirmative duty to care for his patient by introducing a new audience to which the physician must attend - everyone who might come in contact with the patient." Id. at 207 (Cordy, J., dissenting). Similarly, Chief Justice Marshall in expressing her objection to the duty established by the majority, observed:

> The physician's concern for a patient's ability to assess information about needed and appropriate treatment would be forced to compete with concern for an amorphous, but widespread, group of third parties whom a jury might one day determine to be "foreseeable" plaintiffs. The physician would be forever looking over his shoulder.

Id. at 203. Justice Greaney, in advocating for a narrower duty than the majority, stated:

> a physician should not, in ordinary circumstances, be held legally responsible for the safety of others on the highway, or elsewhere, based on the medical treatment afforded a patient. To·a physician, it is the patient (not a third party with whom the physician has no direct contact) who must always come first.

Id. at 197. Finally, Justice Ireland recognized in the majority opinion the "harmful consequences" that would result from a rule that "could create a fear of litigation that would intrude into a doctor's very decision of what medication to prescribe or what

treatment to pursue." Id. at 191-92. These concerns have become manifest in the instant case.

Based on this concern for the autonomy of the physician-patient relationship, all of the Justices in Coombes examined whether imposing a duty to nonpatients would conflict with the paramount duty the physician owes to his patient. In performing this analysis, both Justice Ireland and Justice Greaney concluded that the duty they each proposed would not impose a heavy cost on the physician-patient relationship, because existing tort law already imposed on a doctor a duty to warn a patient of the adverse side effects of medications. Id. at 191, 198 citing Cottam v. CVS Pharmacy, 436 Mass. 316, 321 (2002). Accordingly, Justice Ireland wrote that the duty would require "nothing from a doctor that [was] not already required by his duty to his patient." Id. at 191. Justice Ireland and Justice Greaney also shared the view that a duty to nonpatients was warranted, in part, because it served to protect the patient and the nonpatient from the same harm, the foreseeable risk that side effects of a drug would impair the patient's ability to drive. Id. at 191, 198-99. Thus, the Justices who elected to extend a physician's duty to warn to nonpatients concluded that

this narrow duty would not conflict with the paramount duty that the physician owes to the patient. It therefore would not alter the physician's decisions with respect to the patient.

Importantly, although the majority in Coombes was willing to impose a duty to third-parties based on a physician's duty to warn, Justice Ireland stated that the Court might not be willing to do so based on a physician's "very decision of what medication to prescribe or what treatment to pursue." Id. at 191-92. Justice Ireland recognized that the intrusion on the doctor-patient relationship was more limited based on a doctor's duty to warn than it would be with respect to a doctor's treatment decisions. Id. A doctor's duty to warn, according to Justice Ireland,

> is narrower than a doctor's duty to use due care when deciding to prescribe a particular drug or pursue a particular course of treatment. Id.; see also Restatement (Third) of Torts: Liability for Physical Harm, § 41 comment h (Proposed Final Draft No.1, 2008) (duty to warn is "more limited" than duty to use reasonable care.) Accordingly, Justice Ireland stated that he did not "need to address whether a nonpatient could base a negligence claim on a doctor's negligent prescribing decision, although [he] recognize[d] that protecting the doctor-patient relationship may provide a sound policy reason for limiting such a duty to the patient."

Id. citing McKenzie v. Hawai'i Permanente Medical Group, Inc., 98 Haw. 296, 307-09, 47 P.3d 1209 (2002); Burroughs v. Magee, 118 S.W.3d 323, 331 (Tenn. 2003).

C. Holding that Dr. Hochberg Owed a Duty to the Driving Public Would Go Well Beyond the Confines of the Coombes Decision

Plaintiff's proposed duty in the instant case goes well beyond the narrow duty created in Coombes. Notably, Dr. Hochberg did not prescribe medications which gave rise to the Coombes duty to warn Dr. Riskind. Dr. Hochberg did not even provide specific treatment which would create a special risk, giving rise to a duty to warn. The only risk related to driving flowed from the patient's underlying medical condition and medical advice given, not any treatment provided. The proposed failure of the duty to warn in this case is merely predicated on Dr. Riskind's medical condition of a brain tumor and the fact that Dr. Hochberg was his physician. Dr. Hochberg's treatment of the patient ameliorated risks; it did not create a risk which would give rise to a duty to warn that patient. The extension of a proposed "duty to warn" here goes well beyond the narrow holding in Coombes.

Alternatively, plaintiff bases one theory on Dr. Hochberg's affirmative indication to the patient that he was allowed to resume driving after six months had passed with the patient remaining seizure free. This type of medical decision making was expressly kept out of the Coombes holding. Clinical decision making regarding a patient's ability to safely carry out daily activities cuts to the very heart of the physician-patient relationship. That choice belongs to Drs. Hochberg and Riskind alone. To allow the intrusion of third-party interests would dilute the duty strictly owed to the patient and threaten the very autonomy of the physician-patient relationship. It necessarily creates a conflict of interest between the duty to the patient and the driving public. See, Spinner v. Nut, 417 Mass. 549 (1994). The Justices in Coombes all indicated this was a result to be avoided.

Such an expansion of physician liability is wholly unwarranted. Extending third-party liability in a case such as this fundamentally compromises the independent medical decision making and the paramount duty of a physician to his or her patient alone, which is fundamental to the analysis shared by the Justices in Coombes. Finding that Dr. Hochberg owed Mr. Medina an

extended duty, would constitute a sharp departure from legal precedent in the Commonwealth and threatens the very fabric of the physician-patient relationship.

D. The Court Should Not Impose On Medical Providers a Duty to Warn Patients for the Benefit of Nonpatient Third Parties

Here the plaintiff is asking this Court to go well beyond the Coombes decision by seeking to extend liability based on what medical course Dr. Hochberg and his patient chose to pursue, in direct contravention to the reservations expressed by all of the Court in Coombes. The proposed duty if found would negatively influence medical providers in the Commonwealth by second guessing every medical decision a provider makes with his patient for the exclusive benefit of the public at large. If the plaintiff's claim were allowed to proceed, it would broaden the scope of potential tort liability for medical professionals in Massachusetts. It would be the first time this Court has recognized that a medical provider owes a duty to a nonpatient third-party arising out of the medical provider's decisions regarding the choice of treatment for a patient. Such a decision would necessarily threaten the autonomy of the physician-patient

relationship; a result the Justices in Coombes believed should be avoided.

As the Court acknowledged in Coombes, these harmful consequences are greatest when the intrusion is upon the doctor's "very decision of what medication to prescribe or what treatment to pursue." Coombes, 450 Mass. at 192-93. Individual treatment decisions are best left to patients and their physicians, where the "doctor's concern is focused solely on what, in his or her judgment, the patient's own situation requires." Coombes, 450 Mass. at 211 (Cordy, J., dissenting). Treatment decisions "must take into account complicated issues concerning the potential benefits and risks to individual patients." McKenzie v. Hawai'i Permanente Medical Group, Inc., 47 P.3d 1209, 1216 (Hawai'i 2002).

There is a direct conflict of interest inherent between the duty towards the patient and towards the driving public inherent in this case. Discharging the duty towards the patient would strictly entail a consideration of the underlying condition, history, course of treatment, benefits and inherent risks for the patient's considered activities. Bringing the driving public's interest into that decision-making process inherently places the good of the public above

what is medically necessary for that particular patient. It is also problematic to assume a physician can know what is best for the public based on his individual care of a patient. How is a physician supposed to weigh the potential impact of any medical decision for a particular patient against the backdrop of what is better for the public at large? And how is a physician supposed to know what is in the public's best interest in the context of provisioning care to an individual with unique medical problems and needs? This sets the court in the impossible position to resolve these questions in hindsight by acting as would be "super doctors" over the proper alignment of the physician's duty to the patient with duty to the public at large. Sullivan v. Boston Gas Co., 414 Mass. 129, 135 (1993).

The intrusion of third party considerations could also alter a physician's willingness to encourage a person with a disability to drive, play sports or return to work. After all, a physician would risk no additional liability by instructing disabled or ill patients that they could not engage in activities. Liability only attaches if they advise patients that they can engage in normal life activities. It would be

in both the physician's arguable interest to discourage patients who have suffered disorders and disabilities to resume normal activities, even when medically appropriate.

With the imposition of potential third-party liability, a physician may understandably make decisions, at times, that are not based on the best interest of the patient, but the physician's concern with protecting himself or herself from potential liability to nonpatient third-parties. It encourages the increase of so-called "defensive medicine," ordering tests or procedures that are medically unnecessary, not out of a concern for the patient, but to protect themselves from potential third-party liability. For example, where a physician might otherwise discharge a patient, for fear of liability from the third-party public at large, order a patient remain admitted, driving up costs. Likewise, an expansion of liability may discourage a physician from prescribing certain medications because of a risk of a side effect, such as a seizure or other behavioral effects.

A corollary to the practice of defensive medicine is the real danger that patients will be inundated with

legally mandated warnings which lose any real value.[1] Patients, as do we all, possess limited memory, patience, attention span and other cognitive resources for the retention of medical information.[2] Physicians are in the best position to decide which warnings to give patients on a case-by-case basis, based on the importance to each individual patient. The alternative is that physicians would have to remember the litany of rote legal warnings that must be given in all cases. Much like contemporary pharmaceutical television commercials, the danger is that a specific risk may be drowned out and obscured by the patient desensitization to the volume of warnings given.

Expanding the duty to warn beyond what this Court established in Coombes would expand the scope of potential tort liability for medical providers. Sound policy would not be advanced by imposing on physicians

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[1] Physicians similarly suffer from "alert fatigue" in response to complex electronic feedback mechanisms that can provide them warnings about facts which effect medical decision making such as drug interaction information. Ridgely, M.S. and M.D. Greenberg, 2012. Too many alerts, too much liability: Sorting through the malpractice implications of drug-drug interaction clinical decision support. St. Louis University Journal of Health Law & Policy 5(2):257-296.

[2] M M Hutson; J D Blaha, 1991. Patients' Recall of Preoperative Instruction for Informed Consent for an Operation. The Journal of Bone and Joint Surgery.

such an expanded duty of care. Such an expansion would increase health care costs by expanding the potential liability of physicians. Increased medical malpractice payments, drive up malpractice premiums, which in turn increases health care costs to patients.

II. THE COURT SHOULD HOLD TO NOT EXTEND THE DUTY A PHYSICIAN OWES TO A PATIENT TO THE PUBLIC BEYOND THE BOUNDS OF FORESEEABILITY

Plaintiff's common negligence theory also rests on contention that duty formed under Coombes *because* the plaintiff's alleged harm was reasonably foreseeable. Plaintiff is reliant on Coombes that the very formation of this new duty to third-persons is based on those who are "foreseeably put at risk by [the] failure to warn." 450 Mass. at 190. (See Appellee's Brief pp. 15-16). The plaintiff here contends that because the allegations surround Dr. Riskind's fitness to drive, and Mr. Medina was struck by Dr. Riskind while he was driving that his injuries appear foreseeable and lead to the formation of a third party extended duty. Id. at 16. Given the lack of any risk producing treatment by Dr. Hochberg, however, plaintiff's injuries are well beyond the bounds of foreseeability.

This is a situation in which a consideration of foreseeability is part of the analysis as to whether a duty formed in the first place as opposed to its role in the later consideration of proximate causation. Coombes at 192-94. Foreseeability, whether considered during the formation of duty or as part of the causal chain, asks the same essential question, should the tortfeasor be held responsible for knowing or not knowing the potential consequences of their actions to persons such as the injured party. The foreseeability question is important to the consideration of an extended duty as negligence is not based on a direct relationship between the alleged tortfeasor and the alleged injured party. Instead the Court as in Coombes had to engage in a proximate cause type of analysis to determine whether a legal duty should be created for the benefit of third parties and whether the creation of this duty was justified based on the reasonable foreseeability of the harm to the plaintiff. By this rationale, plaintiff contends that in determining whether a duty should form, the Court must consider whether the plaintiff's injuries were reasonably foreseeable before finding the existence of an extended duty.

This Court squarely addressed the issue of foreseeability for physician liability to third parties in the Leavitt v. Brockton Hospital case. 454 Mass. 37 (2009).

A. This Court's Decision in Leavitt v. Brockton Hospital

The plaintiff in Leavitt was a police officer responding to a report of a pedestrian struck by an automobile. On his way responding to this call, the plaintiff was struck by another vehicle resulting in injuries. Id. at 39. The pedestrian involved in the pedestrian accident was a patient of Brockton Hospital. Id. The pedestrian had just undergone a colonoscopy and was allegedly discharged in an impaired condition. Id. The plaintiff alleged that the hospital and its employees owed a duty of care to the patient which extended to third parties such as him, the responding officer. Id. at 39-40. The plaintiff alleged the hospital had a duty to not release a patient without an escort. Id. The alleged breach of this duty placed other pedestrians and motorists at harm, which included the plaintiff. Id. The hospital defendant filed a motion to dismiss the claim which was granted and then affirmed by the Court. Id.

The plaintiff in Leavitt based his argument that the hospital's duty to the patient extended to third persons on principles of general negligence and on the existence of a special relationship (see infra Section III.) as are alleged in the instant case.[3] This Court rejected both theories. Relative to principals of general negligence, the Court found that the plaintiff's alleged injuries were not reasonably foreseeable to the hospital's conduct:

> The law does not impose liability for all harm factually caused by tortious conduct. See Restatement (Third) of Torts, supra at special note on proximate cause, at 574. Liability for conduct obtains only where the conduct is both a cause in fact of the injury and where the resulting injury is within the scope of the foreseeable risk arising from the negligent conduct. See id. at § 29, at 575; Kent v. Commonwealth, supra at 320 (plaintiff must show cause in fact and that injury was "foreseeable result" of conduct); Foley v. Boston Hous. Auth., supra (no causation where "harm which occurred was not within the scope of foreseeable risk to the victim").

Leavitt at 45.

The Court concluded that the harm that befell Leavitt was not within the scope of foreseeable risk, as "a police officer injured in an accident in which

[3] The plaintiff, a police officer, also raised arguments of the assumption of risk and rescue doctrine not germane here.

the patient is not involved is outside that scope." Id. at 47.

B. Plaintiff's Common Law Negligence Theory Even Further Strains the Concept of Foreseeable Injury

The Court here is faced with an even more attenuated claim to a foreseeable injury. Unlike Coombes, Dr. Hochberg did not at any time provide treatment or prescribe medications which created a risk for driving at any time prior to when Dr. Riskind struck Mr. Medina. Nor did he ever fail to provide a warning based on one of a risk flowing from his prescription or treatment. Also, unlike Leavitt, Dr. Riskind was not like an impaired patient who was still in a medically induced impaired condition prior to injury. Rather; Dr. Riskind was a stable and active patient, who had been successfully treated by Dr. Hochberg for a chronic neurologic issue by providing consultative treatment for a stable brain tumor. Most importantly, Dr. Riskind remained seizure free for 15 months prior to the accident. (A. 207-08, 217-44, & 278-79.)

It could not be foreseeable to Dr. Hochberg that any persons on a public roadway or sidewalks, including plaintiff, would be placed at risk by allowing an

essentially asymptomatic patient to drive. Plaintiff's argument for a foreseeable injury truly rests on the simple fact that Dr. Hochberg had previously treated a patient with an underlying neurologic condition which itself led to the alleged harm. From the foreseeability perspective, this is simply not enough. Under plaintiff's theory, practically every medical provider that treated this patient and knew about this ongoing condition could bear liability to third parties for alleged foreseeable injuries. This could include a primary care provider, orthopedist, nurse practitioner or psychiatrist, for example. Similar to Dr. Hochberg, every provider would have had the same putative duty to warn this patient about the risks of his known underlying medical condition for the benefit of public motorists. This is possible as the duty as espoused has no relation to the treatment provided to the patient or the degree to which the provider could even assess driving ability. As Appellant rightly stated this defined duty would be amorphous, subject only to the imagination of plaintiff expert witnesses who were willing to provide opinion letters. By this logic every medical provider who treated this patient, knew of the condition and failed to deliver a warning could

be held responsible for any resulting injuries based on the medical condition for the duration of the patient's lifetime.

Laid bare, the plaintiff-appellant's argument seeks to impose liability upon Dr. Hochberg based on the fact of the physician-patient relationship alone. Dr. Hochberg prescribed no medicine or provided no treatment which would have triggered a duty to warn. It was the nascent risk of the illness itself and his choice to treat this patient which alone serves as the basis of plaintiff's theory. Such a claim is well beyond the bounds of foreseeability for the plaintiff's claimed injuries.

III. MASSACHUSETTS HAS NOT RECOGNIZED THAT THE PHYSICIAN-PATIENT RELATIONSHIP CONSTITUTES A "SPECIAL RELATIONSHIP"

A. The Physician-patient Relationship is Not a "Special Relationship"

This Court has plainly rejected the contention that the physician-patient relationship constitutes a "special relationship" for purposes of extending third party liability. Leavitt v. Brockton Hospital, 454 Mass. 37, 41-42 (2009). Coombes v. Florio, 450 Mass. 182, 187, 205, 207 (2007); id. at 45. Despite the existing legal precedent, Plaintiff is asking this

Court to expand the law on special relationships to include the physician-patient relationship. Such an expansion is not warranted.

It should be pointed out that plaintiff-appellant's argument conflates the notion of "specialty" in reference to the scientific expertise of the medical provider with the "special relationship" legal doctrine. (See, Appellee's Brief pp. 11-13). A doctor's specialty and adherence to the medical standard of care has nothing to do with the development of the "special relationship" doctrine in this Commonwealth as set out below.

The "special relationship" doctrine is an exception to the general rule that parties "do not owe others a duty to take action to rescue or protect them from conditions [the parties] have not created." Cremins v. Clancy, 415 Mass. 289, 296-97 (1993) (Greaney, J., concurring). See Kavanagh v. Trustees of Boston Univ., 440 Mass. 195, 202-03 (2003); see also, RESTATEMENT (SECOND) OF TORTS § 314 (1965) ("The fact that the actor realizes or should realize that action on his part is necessary for another's aid or protection does not of itself impose upon him a duty to take such action.") While everyone has a duty to act reasonably,

an affirmative duty is required to hold one liable for their omission or failure to act. See, e.g., RESTATEMENT (SECOND) OF TORTS § 314, note (c) ("The origin of the [affirmative duty] rule lay in the early common law distinction between action and inaction, or "misfeasance" and "non-feasance.")

In accord with the RESTATEMENT SECOND OF TORTS § 315 (1965), this Court has recognized a "special relationship" exception to the general rule that actors do not owe third parties an affirmative duty.

> There is no duty so to control the conduct of a third person as to prevent him from causing physical harm to another unless a special relationship exists between the actor or the third person which imposes a duty upon the actor to control the third person's conduct . . .

See Coombes, at 193-96 (2007); Kavanagh at 202-03; Luoni at 731 (2000). See generally, RESTATEMENT (THIRD) OF TORTS: LIAB. PHYSICAL HARM § 41 (P.F.D. No. 1, 2005).[4]

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[4] The Restatement draft, in relevant part, provides:

> (a) An actor in a special relationship with another owes a duty of reasonable care to third persons with regard to risks posed by the other that arise within the scope of the relationship.
>
> (b) Special relationships giving rise to the duty provided in Subsection (a) include:
>
> (1) a parent with dependent children,
>
> (2) a custodian with those in its custody,

This Court has recognized that a special relationship exists in several categories of cases. First, this Court has recognized a special relationship when a statute creates an affirmative duty of care to foreseeable third persons as contemplated in the liquor liability cases. Adamian v. Three Sons Inc., 353 Mass. 498 (1968) (bar owner held liable to those injured by intoxicated patron.) Physicians do not have a statutory or common law duty to the general public in treating a patient so this exclusion does not apply in this case.

Second, this Court has recognized a special relationship when the defendant owes a duty to an identifiable limited class of persons that includes the plaintiff, then the defendant may owe a duty to the plaintiff to protect him from the dangerous or unlawful acts of a third person. See Mullins v. Pine Manor College, 389 Mass. 47 (1983) (holding a college owes a duty to its students to take reasonable steps to protect them from harm from foreseeable criminal acts). Here, the doctor had no preexisting relationship with

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> (3) an employer with employees when the employment facilitates the employee's causing harm to third parties, and (4) a mental-health professional with patients.

RESTATEMENT (THIRD) OF TORTS: LIAB. PHYSICAL HARM, § 41 (P.F.D. No. 1, 2005).

an identifiable class of persons like students on a campus, so this exception does not apply. The class at issue by plaintiff's own account is "driving public," whereas Dr. Hochberg owed a duty to his patient alone, not to protect the entire driving public. It is irrelevant that Dr. Riskind was a member of the driving public. He also may belong to many classes of persons, (i.e., "physician in the Commonwealth," "a male," etc.) The key is that Dr. Hochberg does not previously owe a duty to protect this class of persons like a school might owe its students.

Third and fourth, this Court has recognized specia1 relationships where one party has an obligation to control another's conduct (discussed in detail below.) The Court has recognized a special relationship based on the element of control in certain specific types of relationships, including a parent and child, a landowner and licensee, a police officer and prisoner, and a parole officer and parolee. See Irwin v. Ware, 392 Mass. 745 (1984) (special relationship when police released intoxicated motorist into driver); Jean W. v. Commonwealth, 414 Mass. 496 (1993) (special relationship between parole officer and parolee). This Court has specifically rejected the contention that a

regular health care provider controls a patient in Leavitt v. Brockton Hospital, 454 Mass. 37, 41-42 (2009). (See infra Section III. B.).

One Massachusetts trial court has also recognized an important sub-category of special relationships that exist between a mental-healthcare provider and patient while the patient is in that provider's custody. See Carr v. Howard, 5 Mass. L. Rep. 63 (Norfolk Super. Ct. 1996) (J. Cowin) (holding a special relationship between psychiatrist and a psychiatric hospital that have custody over patients who are dangerous to themselves and others). Plaintiff cites to Carr v. Howard, to support the proposition that regular healthcare providers have a special relationship with their patients. The instant case can be immediately distinguished from Carr which involved mental health professionals who had actual physical custody of a committed patient with dangerous propensities. The plaintiff in Carr had a stronger claim given that the mental health professionals were authorized to exert physical control over a committed patient. This holding is in accord with the analysis found within the RESTATEMENT (THIRD) OF TORTS: LIAB. PHYSICAL HARM § 41, Comments (g)-(h), which suggests that a black letter

special relationship should be specifically recognized for mental healthcare providers, but notably not extended to regular healthcare providers.

B. A Physician Does Not Control the Patient

Unlike a parent or police officer, a healthcare provider does not exert control over a patient's conduct. Id. See RESTATEMENT (THIRD) OF TORTS: LIAB. PHYSICAL HARM § 41 ("Patients who are not in custody cannot be "controlled" in the classic sense, and the duty imposed is only one of reasonable care.") Comment (g). The physician-patient relationship lacks the element of control necessary to be considered a special relationship.

The Court in Leavitt held:

> We have not previously recognized, and do not now recognize, a duty to a third person of a medical professional to control a patient (excluding a patient of a mental health professional) arising from any claimed special relationship between the medical professional and the patient.

Also in Coombes the Court noted that:

> a physician's advice may not be followed, of course, and a physician has no ability physically to prevent a patient from driving (or engaging in any behavior) once that patient departs from the physician's office . . . By informing (or otherwise counseling or advising) a patient of known potential side effects of prescribed medications that

> might affect the patient's ability to drive a motor vehicle safely, and where appropriate, warning the patient not to drive at all, a physician may effectively avoid any risk of danger to the patient and others.

Coombes at 199-200.

A physician-patient relationship does not entail reciprocating obligations. The physician is under an exclusive duty to the patient to provide sound medical advice and treatment; the patient is under no obligation to follow that advice. Consequently, the patient is unlike the motorist pulled over by the police officer, or the parent and child. Whatever advice a physician provides to a patient, the patient is free to ignore. Therefore, without any obligation to adhere to the advice given, the control required for the imposition of a special relationship is lacking.

Indeed, the "informed consent" doctrines are designed to put the patient in a position to weigh their own risks and make their own medical decisions. The physician's judgment does not typically substitute for the patients where patient risk is involved. The physician normally owes the patient a duty to explain the necessary medical facts so the patient can make informed treatment decisions with an appreciation for foreseeable risks. Harnish v. Children's Hosp. Medical

Center, 387 Mass. 152 (1982); ("Every competent adult has a right "to forego treatment, or even cure, if it entails what for him are intolerable consequences or risks however unwise his sense of values may be in the eyes of the medical profession.") (quoting Wilkinson v. Vesey, 110 R.I. 606, 624, 295 A.2d 676 (1972)); see also, Lubanes v. George, 386 Mass. 320, 325 (1982). Thus a physician cannot be said to normally exert the same kind of direct control we recognize in special relationships.

The clearest example of a physician's lack of control over the patient has to be that a physician lacks the ability to exert physical control over a patient. Patients in the modern healthcare setting have rights which protect them from physical or chemical control exerted by their providers.[5] During treatment, healthcare providers only take physical custody of their patients in heavily regulated circumstances that invoke the immediate physical safety of the patient or when the patient has been deemed incompetent. If a competent, adult patient chooses to

[5] "Restraint or seclusion may only be imposed to ensure the immediate physical safety of the patient, a staff member, or others and must be discontinued at the earliest possible time." H 42 C.F.R. § 482.13(e) (emphasis added).

disregard warnings or instructions, physicians usually do not have recourse to correct the patient's conduct the way a parent or police officer might. As a result, a healthcare provider may give warnings, recommendations and instructions to a patient, but cannot otherwise directly control the patient's conduct. Consequently, the relationship between a medical provider and a patient lacks the element of control necessary to consider it a special relationship for the purpose of imposing potential third-party liability on the medical provider.

C. Extending the Special Relationship Doctrine to the Physician-Patient Relationship Would Be Contrary to Sound Public Policy

The Court should not expand the potential tort liability of medical providers by finding that a special relationship exists between a medical provider and a patient. If medical providers were deemed to have a "special relationship" towards their patients when providing medical advice, they would be under an affirmative legal obligation to exert control of their patient's conduct for the benefit of third parties. See Coombes at 193-96 (2007); Kavanagh at 202-03. For the reasons discussed earlier, imposing such a duty on

a medical provider would place it in the untenable position of having potentially conflicting duties, to the patient on the one hand and nonpatient third parties on the other. Such an expansion of a medical provider's potential tort liability is unwarranted as it would increase health care costs and intrude dangerously, and in unprecedented fashion, on the autonomy of the physician-patient relationship.

CONCLUSION

For the foregoing reasons, the Court should hold that a medical provider's potential liability to a nonpatient third-party is limited to the medical provider's duty to warn a patient, and does not extend to the medical provider's decisions regarding the treatment of a patient. Holding otherwise would place virtually all medical providers as potential tortfeasors beyond the bounds of foreseeability. Likewise, the Court should not expand a medical provider's potential liability to a nonpatient third party by recognizing a special relationship between a physician and a patient. The Court, therefore, should affirm summary judgment for Dr. Hochberg and decline the plaintiff's proposal to expand the scope of

potential tort liability for medical providers in the Commonwealth.

Respectfully submitted,

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ADDENDUM

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Patients' Recall of Preoperative Instruction for Informed Consent for an Operation*

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ABSTRACT: **Thirty-eight consecutive patients who were admitted to the hospital for total joint replacement were studied to determine their understanding of the elements of informed consent at the time when they signed the consent document before the operation and their recall of those elements six months after the operation.**

All patients received instruction from the same patient-educator before the operation. Each patient was asked to respond verbally to a questionnaire about the preoperative instruction. If a question was not answered correctly, tutoring was given until the patient gave the correct response. The consent document was not presented for signature until the patient could answer all questions correctly.

In an interview six months after the operation, thirty-six of the thirty-eight patients were asked the same questions that they had answered before the operation.

The recall of risks and benefits six months after the operation was compared with the understanding of risks and benefits that had been demonstrated before the operation by both the verbal questioning and the signed consent document. At six months, the number of patients who recalled the risks ranged from nine (25 per cent) who remembered the risk of infection to only one who remembered the risk of damage to a nerve or artery. More patients recalled the potential benefits: eight (22 per cent) for relief of pain and improved function and five (16 per cent) for improved motion.

Several previous studies have reported the lack of recall by patients of details of preoperative interviews. Robinson and Merav tape-recorded detailed informed-consent interviews with twenty patients before an operation. Four to six months after the operation, all patients failed to recall important parts of the interview, and sixteen of the twenty positively denied that some major items had been discussed at all. Priluck et al. tested the recall of information by patients two to eleven days after an operation on the retina. Over-all retention, based on correct answers to questions, was 57 per cent. Leeb et al. tested 100 patients to determine recall within seven days after a preoperative discussion; recall was only 35 per cent. We began this study to determine whether intensive preoperative teaching by a patient-educator could improve later recall of information presented in the process of obtaining informed consent.

Materials and Methods

Thirty-eight consecutive patients who had been admitted to the hospital for an elective operation for total joint replacement agreed to participate in this study. The ages ranged from thirty-one to eighty-six years (mean age, sixty-two years). There were fourteen men and twenty-four women. The average educational level was 11.9 school years. Twenty-one patients had had a previous operation; seventeen of these had been orthopaedic procedures.

Each patient received instruction from the same educator. This instruction included a discussion of the diagnosis, alternative treatments, risks and benefits of alternative treatments, and the recommendation of the attending surgeon. Each session was with only one patient and included a slide-tape presentation and a model of the joint and prosthesis. Typically, this instructional session lasted thirty to sixty minutes.

Patients were not informed of the study until after the session of instruction for informed consent. They were then asked to participate, and all agreed. Next, the educator administered a verbal questionnaire to assess the patient's recall of the elements of informed consent that had been given during the session of instruction (Table I).

There were thirteen questions, some of which had multiple parts and one that asked the patients to circle, on a diagram of the body, where the operation would take place (Table I). The patients were also asked if they understood the instructions and if all of their questions had been answered. Answers were recorded verbatim. Criteria for correct responses were determined before the study, and the use of layperson's terms was taken into account.

After the patient had completed the verbal questionnaire, incorrect answers were identified, and the educator tutored the patient until every question was answered correctly. The patient was then given the document to sign, to indicate consent to the operation. The session for the verbal questionnaire and tutoring lasted thirty to sixty minutes.

* No benefits in any form have been received or will be received from a commercial party related directly or indirectly to the subject of this article. No funds were received in support of this study.

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TABLE I

VERBAL QUESTIONNAIRE FOR INFORMED CONSENT

1. In your own words, describe what is wrong with you.
2. What treatment will you be having?
3. Are there risks from this treatment? What are they?
4. Are there benefits from this treatment? What are they?
5. What other ways could you be treated?
6. Are there risks with the other treatments? What are they?
7. Are there benefits with the other treatments? What are they?
8. What treatment did the doctor recommend?
9. Who explained your disease and treatment to you?
10. Do you think you understand what is wrong and what is to be done?
11. Did you have a chance to ask questions? Were there any questions not answered?
12. Are you ____ not nervous ____ a little nervous ____ very nervous about your operation?
13. Circle the part of the body where your operation will take place. If you can, show where the incision will be.

Postoperative Interview

Thirty-six of the thirty-eight patients were interviewed by telephone an average of six months (range, five to eleven months) after the operation, to determine recall of the items that had been taught during the instruction for informed consent. The remaining two patients had died during the period of this study.

For these interviews, a person unknown to the patient and not associated with the initial interview administered a questionnaire identical to the one that the patient had answered after the instruction for informed consent, except that the patient was asked to describe the location of the operation rather than to make a circle on a diagram. The answers were recorded verbatim and were compared with the ones that had been given immediately after the instruction but before tutoring (Table II).

Results

Statistical analysis was performed with the Wilcoxon test for matched pairs and the binomial probability test. Using chi-square analysis, we studied the association between recall and the patient's age, sex, educational level, assessment of anxiety, and previous operations.

When all thirty-eight patients were questioned immediately after the preoperative instruction and before tutoring, twenty-five (66 per cent) recalled the potential benefit of relief of pain and twenty (53 per cent), improved function, but only nine (24 per cent) recalled discussion of the potential benefit of increased range of motion. The number of patients who recalled the risks ranged from thirty-one (82 per cent) who remembered the risk of infection to only four (11 per cent) who recalled the risk of damage to a nerve or artery (Table II). All patients said that they understood the information presented and that all of their questions had been answered, even though they could not recall some of the material.

Before being asked to sign the consent document, each patient was able, through tutoring, to answer all questions correctly. Thus, 100 per cent of the patients could recall all of the information, including the risks and benefits, at the time when they signed the consent document.

During the postoperative interview six months later, eight patients (22 per cent) remembered discussing the potential benefits of relief of pain; eight patients (22 per cent), improved function; and five (16 per cent), increased range of motion. The number of patients who recalled the possible risks ranged from nine (25 per cent) who remembered the risk of infection to only one who recalled the risk of damage to a nerve or artery. Twenty-nine patients (81 per cent) recalled who had instructed them and thirty-four (94 per cent), what treatment had been recommended. All but one said that they understood what had been done at the operation, and all patients said that all of their questions had been answered before the operation (Table II).

More patients forgot the risks six months after the operation than immediately after the instruction for informed consent but before tutoring ($p < 0.001$), but the difference in recall of the benefits at these two points was not significant ($p = 0.13$). Patients forgot both benefits and risks, but forgot more about risks ($p = 0.05$).

We could not draw any conclusions about differences in the results due to the sex or age of the patients.

Patients who had had more than twelve years of formal education had a significantly greater recall of instruction than did those who had had twelve years or less ($p < 0.01$).

Patients who assessed themselves as nervous before the operation tended to remember more during the questioning at the instruction for informed consent, but their recall six months later was not shown to be significantly better ($p > 0.05$).

TABLE II

PERCENTAGE OF PATIENTS WHO RECALLED PREOPERATIVE INSTRUCTION*

Instruction	Recall: Immediate, before Tutoring (38 Patients)	Recall: Six Months after Operation (36 Patients)
Diagnosis	100	92
Treatment	100	94
Benefits		
Relief of pain	66	22
Increased range of motion	24	16
Improved function	53	22
Risks		
Death	72	28
Infection	82	25
Pain	14	6
Loss of range of motion	22	14
Loosening of prosthesis	25	11
Damage to nerve or artery	11	3
Major medical complication	61	25
Surgeon's recommendation	100	94
Were all instructions understood?	100	97
Were all questions answered?	100	100
Identity of instructor	72	81

* When they signed the informed-consent document after the tutoring session, all patients recalled 100 per cent of all of these items.

The recall of patients who had had a previous orthopaedic operation and of those who had had another operation was not significantly better ($p > 0.05$).

Discussion

It is apparent from this study that, after an operation, patients' recollections are not reliable about the risks and benefits of the operation, despite preoperative instruction and tutoring.

Our results do not suggest, however, that it is fruitless to tutor patients to obtain a more informed consent. On the contrary, we believe that a tutoring session may increase a patient's recall of the elements of informed consent at the time when the consent document is signed. However, even with tutoring, patients' recollections postoperatively of what they had been told were poor.

Our study differs from those reported previously in that we conducted a teaching session for informed consent followed by a tutoring session, to guarantee that every patient could recall all of the elements of informed consent before signing the document. All patients indicated that they understood the information. Therefore, we believe that all of our patients gave truly informed consent to the operation. Despite our best efforts, however, our data showed the long-term rate of recall to be similar to that in other studies.

Our patients, when informed of the risks of the operation, may have selectively recalled and emphasized the favorable outcomes of decreased pain and increased function and range of motion[3]. It is known that, when exposed to sources of danger, people may fail to remember some events surrounding that danger as a way to avoid the most anxiety-producing details[1].

In a study by Hassar and Weintraub, two-thirds of the participants in a clinical trial of an anti-inflammatory medication did not remember, when given a factual test, being informed about an adverse effect that was an important risk. Some subjects remembered, but misunderstood what they had been told, and others had erroneous ideas about the trial and the medication. The patients in that study pointed out their great anxiety during the initial interview. The authors suggested that this anxiety may have decreased the ability of the patients to concentrate and to retain information.

Our results raise the important question of whether some methods of instruction increase a patient's recall of the elements of informed consent six months or more after an operation. However, because the validity of a consent is determined by the patient's recall at the time when the consent is given, and because there may be some psychological advantage in forgetting risks and dangers, we suggest that techniques should concentrate on providing the information necessary for a patient to give informed consent when the consent document is signed, while allowing natural defense mechanisms to determine what will be remembered for a longer period.

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CERTIFICATE OF COMPLIANCE

This brief complies with the rules of court that pertain to the filing of briefs, including, but not limited to: Mass. R. A. P. 16(a)(6) (pertinent findings or memorandum of decision); Mass. R. A. P. 16(e) (references to the record); Mass. R. A. P. 16(f) (reproduction of statutes, rules, regulations); Mass. R. A. P. 16(h) (length of briefs); Mass. R. A. P. 18 (appendix to the briefs); and Mass. R. A. P. 20 (form of briefs, appendices, and other papers).

/s/ *Chad P. Brouillard*

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